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	345209	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

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F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record reviews, the facility failed to identify medical symptoms for 1 of 3 sampled residents with restraints and failed to implement systematic approaches to reduce restraints(Residents #39). Facility policy titled, " Restraints " dated 7/30/2011, read in part: " residents have the right to be free from restraints that are not medically necessary or are used for the purpose other than resident benefit or safety. Restraints shall be used only where alternative methods are not sufficient to protect residents or others from injury and are not a substitute for less restrictive forms of protective restraint. All residents would have an assessment performed to determine the safety and protective needs of the resident prior to the application of restraint or medical protective devices. Section identified as restraint must be: selected only when other less restrictive measures have been found to be ineffective to protect the resident or others from harm. A physician ' s order, written modification to resident ' s care plan and the condition of the restrained resident must be continually assessed, monitored and reevaluated. In addition, restraint verification of the order for restraint that included rationale for	F 221	Resident #39 will be evaluated by Therapy (Attachment 1) and Director of Nursing will complete a Restraint Assessment Form (Attachment 2). The other corrective action will be completed by Independent Contractor per CMS letter (Attachment 3).	2/8/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/7/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 restraint, length of time and type of restraint to be used and the extremity or body part(s) to be restrained. Determine if alternative. Less restrictive methods have been attempted, however were ineffective and explain to resident/family the plan and rationale for using restraints and the condition/behavior required for release from restraint. Resident #39 admitted to the facility on 2/17/09 and readmitted 10/5/12. The diagnoses included congested heart failure, alzheimer dementia, hypertension, pacemaker , and osteoarthritis. The Minimum Data Set(MDS) dated 11/1/12, indicated short and long term memory and decision making impairment. She required extensive to toal assistance with acitivies of daily living. Resident #39 was also coded as chair to prevent rising and with upper body contracutres. Review of last rehabilitation evaluation dated 5/25/10, revealed that Resident #39 was assessed for positioning and demonstrated good upright positioning in a standard with chair with a cushion. There was no indication a assessment was done for the use of lapbuddy or any other device. The physician's order dated 9/9/11, documented the lap buddy when in wheelchair to prevent rising/leaning forward. There was no indicated of the duration or frequency for the use and removal of restraint documented. Review of the restraint consent dated 9/9/11, for the use of lap buddy or bed bolster pad, revealed the reason for the use of the devices was due to Resident #39 leans in wheelchair. The signatures on the document did not include the resident and/or representative or	F 221		

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F 221	Continued From page 2 physician. Review of the care plan dated 11/7/12, identified the problem as; Resident #39 had the potential for discomfort, injury and loss of autonomy related to the use of bolster pads and lap buddy when in wheelchair. The goal included that Resident #39 would be free from discomfort and injury and autonomy would be maintained at highest possible level. The approaches included Resident #39 would be reminded to use the call light for assistance, exercise to maintain range of motion, attend activities and provide adequate stimulation and assess for least restrictive restraint. There was no frequency of when to apply or remove the restraint documented. Dining observation on 1/8/13 at 11:42AM, Resident #39 was seated at the dining room table with lap buddy in place. Resident #39 was assisted with the meal by the DON who prepared the meal and blew on the resident ' s food before serving her several bites. The DON stood over Resident #39 for 10 minutes while she fed.After 10 minutes of feeding Resident#39, the lapbuddy was removed and a pillow was put in place. Resident#39 was repositioned without difficulty and did not have any involuntary movements or lean in any directions. During an obsevation on 1/9/13 at 8:07AM to 8:48AM, Resident #39 was being fed with lap buddy in place. Resident #39 did not have splint on right hand or palm guard in left hand. During a meal observation on 1/10/13 at 8:00AM to 8:28AM, Resident#39 was seated in wheelchair without lapbuddy, wheelchair was	F 221		

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F 221	Continued From page 3	F 221		

facing the wall and not under the table. Resident#39 was being fed from a side angle position. Resident#39 was seated in an up right position without leaning in either direction while staff fed breakfast. She had a wash cloth in left hand and no splint on right. NA #2 fed Resident #39 and there was no leaning in any direction, no involuntary or reptitive movements and no behaviors. Resident #39 was very calm and cooperative. The right arm was hanging over arm rest in relaxed postion without splint and or hand roll/palm guard in left hand.

Review of the care area assessment(CAA) for activities of daily living, falls, restraints and incontinence dated 11/1/12, revealed that Resident #39 required extensive to total assistance with ADL ' s, mobility, transfers and locomotion once in the wheelchair off the unit. Resident #39 did not ambulate. Resident #39 had contractures and splints were applied and range of motion was not identified. The restraint CAA revealed that it would be proceeded to care plan due to potential for injuries related to use of restraints. The CAA did not identify they type of restraint being used or the application/removal frequency.

The form titled pre-physical restraint and reduction assessments dated 2/9/10 through 9/17/11, revealed the restraint device was a lap buddy used for leaning forward and safety. The medical symptom which led to the consideration of the physical device and least restrictive measured to be used was left blank. Resident #39 required extensive assistance with bed mobility and transfers, incontinence of bowel and bladder. Review of the pre-restraining evaluation

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F 221	Continued From page 4 dated 2/1/12, documented no change. Additional review of the interdisciplinary progress notes dated 3/1/12, through 12/10/12, documented that resident had lap buddy in place due to leaning forward and for safety. There was no further indication of what the assessment of evaluation included for the attempts or reduction of the restraint or referrals to therapy department for least restrictive device. There was no documentation of methods or tools used to assess the continuation or medical indication for the restraint. Review of the nurse's notes from 2/23/12 through 1/19/13, revealed that Resident #39 had not had any falls from the bed or wheelchair. Additional, review of the record revealed there was no documented behaviors of leaning forward, repetitive movements or referrals to therapy for evaluation of positioning. Review of the falls risk form did not document any falls for past two years. During an interview on 1/9/13 at 2:40PM, the occupational therapist(OT) indicated that bed bolster and lap buddy was family preference. The nursing department was responsible for evaluating and assessing the use of the lap buddy. During an interview on 1/9/13 at 2:47PM, the DON indicated that she was responsible for restraint assessment/evaluation and therapy department did not send orders or referrals they made recommendations. DON acknowledged that there was no system in place for assessment of restraints or a specific evaluation process for restraint assessment or referral to therapy. She	F 221		

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F 221	Continued From page 5 added that a system should be in place for ensuring that restraint efforts were documented and to include the frequency and use of restraints. Physician ' s orders should be clear as to what was expected for the use of restraints. During a follow-up interview on 1/9/13 at 3:29PM, the DON stated that she did not have any supporting documentation to support where Resident#39 was leaning from the chair or there was a concern with excessive movements or attempts of resident getting out of bed or falling from bed. She added that Resident#39 had not been seen by therapy for any other assessments or evaluations since 2009 for the use of the bed bolsters, lap buddy or splints. She confirmed and acknowledged the IDT(interdisciplinary) notes dated 3/1/12 through 12/10/12, revealed the resident needed the lap buddy as a positioning device in the wheelchair. There was no indication of any observations of the resident leaning in any direction or had a positioning concern or evaluation for positioning related to the lap buddy. During an interview on 1/913 at 4:48PM, N#4 indicated that Resident #39 was fed with the lap buddy in place as well to keep resident in position. She stated she had not seen the resident slid in the bed, unless she needed to be repositioned per the sign above the bed. She was repositioned every two hours During an interview on 1/9/13 at 4:53PM, Nurse#1 indicated that she primarily worked second shift and the resident was put to bed after meals. Resident would roll from side to side in bed but does not have repetitive movements or attempts to get out of bed. If the resident stayed	F 221		

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F 221	Continued From page 6 up past 7:00PM, Resident #39 got tired and may lean slightly forward as though she was tired. Resident#39 was seated in wheelchair during second shift interviews and she was sleeping in wheelchair to the right side arm rest. She had no repetitive movements. Each staff indicated that the position that resident was in during the interviews was what she would generally be in until she went to meals or bed. During an interview on 1/9/13 at 4:59PM, NA#5 primary worker second shift indicated that once the resident was placed in bed she remained in place. She added that the lap buddy was on at all times and she did not know when it should be removed other than bathing/care etc. She indicated that she had not seen the resident lean in any directions. During an interview on 1/10/13 at 10:46AM, three family members(included responsible person) stated that the DON told them that the lap buddy was put into place becasue Resident#39 was leaning and for safety. Family indicated that the risk facotor of restraint had not been explained and they did not request the lap buddy. The family preference and the resident preference was the use of the geri-chair because Resident#39 appeared to more comfortable rather than the wheelchair. It was further stated that Resident #39 did have a preferred side that she leaned on which was right side, but no-one had ever mentioned reassessing her for positioning or other type of wheelchair. Family members knew that Resident #39 was uncomfortable in the wheelchair, but didnt really know why the pillow(lap buddy) was put into place other than what nursing told them and the family	F 221		

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F 221	Continued From page 7 did not request the lap buddy nor have they seen Resident #39 without it unless resident was in bed.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and medical record reviews, the facility failed to obtain consent for posting of medical information in the residents ' rooms for 2 of 2 residents (Resident #25 and #39). The facility failed to provide a dignified dining experience for 1 of 3 sampled residents in restraints during meals and blowing on the resident ' s food before serving (Resident #39). The findings included 1. Resident # 25 was admitted to the facility on 10/2/10 with diagnoses including hypertension, diabetes, dementia and cerebral vascular disease. Review of the Minimum Data Set dated 8/20/12 revealed severe memory impairment, bilateral contractures of upper and lower extremities. During an observation on 1/7/13 at 12:02PM, a sign was posted above Resident #25 bed that read ATTN: CNA ' s(certified nursing assistants) and nurses please remove Resident #25 hand	F 241	The signs in Resident Rooms Number 25 and Number 39 were removed. All signage from all other Resident Rooms have been removed. No signage will be placed in Resident Rooms without family written consent (Attachment 4). Safety Committee will monitor compliance during monthly walk-throughs. Nursing Staff will be in-serviced on the cited instances with a dignified dining experience. To correct any other Residents who may have been potentially affected, the in-service will include all aspects of a dignified dining experience ((Attachment 5). Designated Staff will monitor at meal times any concerns with a dignified dining experience. Any findings will be reported immediately to the Director of Nursing for correction (Attachment 6). Findings will be reviewed at our quarterly Quality Assurance Meeting (Attachment 7).	2/8/13

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F 241	Continued From page 8 splints when she was laid down .Thanks. During an observation on 1/9/13 at 9:27AM, NA#1/restorative Aide was in resident room assisting nurse with medication administration. Signage posted above bed: " Attn CNAs and Nurse please remove Resident #25 hand splints when she was laid down. Thanks. " Restorative aide performing range of motion on Resident #25 stated that splints were on during the day on 1st shift and when she came in the splints were on at night. The sign was put up to remind staff not to leave splints on at night. The nurse put sign up. She added that this was dicussed with the DON and sign should have been removed by now. During an interview on 1/9/13 at 9:54AM, the DON(director of nursing) stated that verbal discussions was held with the family regarding the signage for care. There was no written documentation of the discussion or agreement to the posted information. She indicated that she was unaware there needed to be documentation of the consent to post care needs for staff to perform. During an interview on 1/9/13 at 10:01AM, family member stated that he really didnt know why it was there and that he came in one day and it was posted up there, no one really said why, he thought it was to help remind staff what to do. During an interview on 1/9/13 at 10:54AM, the Sw(social worker) indicated there was nothing in writing to indicate family was in agreement for care needs to be posted on resident walls. SW added that she was not part of the discussion when information was posted or aware of when	F 241		

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F 241	Continued From page 9 there was a posting unless she had direct verbal contact with the resident/family. Review of the medical record for Resident #25 did not provide documentation of discussion or permission for the provision of care to be posted above the bed. Additional, review of the admission packet did not include consent for provision of care to be posted in resident rooms. 2. Resident #39 admitted to the facility on 2/17/09 and readmitted 10/5/12. The diagnoses included congested heart failure, alzheimer dementia, hypertension, pacemaker and osteoarthritis. The Minimum Data Set(MDS) dated 11/1/12, indicated short and long term memory and decision making impairment. Dining observation on 1/8/13 at 11:42AM, Resident #39 was seated at the dining room table with lap buddy in place and no palm guard or splints. Resident #39 was assisted with the meal by the DON who prepared the meal and blew on the resident ' s food before serving her several bites. The DON stood over Resident #39 for 10 minutes while she fed.After 10 minutes of feeding Resident#39, the lapbuddy was removed and a pillow was put in place. Resident#39 was repositioned without difficulty and did not have any involuntary movements or lean in any directions. During an obsevation on 1/9/13 at 8:07AM to 8:48AM, Resident #39 was being fed with lap buddy in place. Resident #39 did not have splint on right hand or palm guard in left hand. During an interview on 1/9/13 at 8:50AM,NA#1 and NA#2, NA#2, stated that when Resident #39	F 241		

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F 241	Continued From page 10	F 241		

was fed the lap buddy was kept on because the resident would lean to the side. Both staff stated that the resident could sit in an upright position if the lap buddy was removed at the table. NA #1 stated that the lap buddy was not removed unless Resident #39 was being changed or put to bed. She added that the lap buddy was in place per family request. Resident #39 has never fallen and when the lap buddy was removed Resident#39 was seated in geri-chair or wheelchiar, resident would just lean slightly forward to reach for something or chew on her clothing protector, but has never fallen foward. There was no splints, hand rolls or cloths in either hand.

During an interview on 1/9/13 at 9:02AM, the DON, stated that the lap buddy was used for positioning and due to leaning forward and the resident had dementia and could not remember to re position self. She acknowledge and confirmed that she blew on the resident food 1st becuase she thought it was too hot. She stated that was not something she would expect staff to do. She confirmed that she stood over the resident and fed the resident for 10 minutes with lap buddy in place before the resident was repositioned with the use of the pillow and lap buddy removed and later pushed under the table.

During an interview on 1/9/13 at 9:10 AM, NA #3 stated that the lap buddy was removed sporadiacally when staff remember to remove it or when Resident #39 was placed at the table. She stated that family wanted the lap buddy and the primary removal was when Resident #39 was provided care or when put to bed. She indicated that when the lap buddy was removed she leaned forward or moved around. She has not had a fall

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F 241	Continued From page 11 in a long time. During an observation on 1/9/13 at 9:20AM, a was sign posted over bed : Do not leave flat on her back, raise HOB up at least 30 degrees. Resident#39 was seated in room with lap buddy in place, there was no involuntary movements resting on right side arm rest sleep and feet firmly placed on floor. The blue splint in chair. There was no hand rolls/palm guard in either hand. During an interview on 1/9/13 at 9:54AM, the director of nursing(DON) stated that verbal discussions are held with the family regarding the signage for care. There was no written documentation of the discussion or agreement to the posted information. She indicated that she was unaware there needed to be documentation of the consent to post care needs for staff to perform. During an interview on 1/9/13 at 10:54AM, the Sw(social worker) indicated there was nothing in writing to indicate family was in agreement for care needs to be posted on resident walls. SW added that she was not part of the discussion when information was posted or aware of when there was a posting unless she had direct verbal contact with the resident/family. During an observation on 1/9/13 at 2:00PM, Resident#39 lying in bed with no physical movement and bed bolster pads in place. The wash cloth was in left hand and splint on right arm. The bed was elevated per sign above bed. During an interview on 1/913 at 4:48PM, N#4 indicated that Resident #39 was fed with the lap	F 241		

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buddy in place as well to keep resident in position. She stated she had not seen the resident slid in the bed, unless she needed to be repositioned per the sign above the bed. She was repositioned every two hours.

During an interview on 1/9/13 at 4:59PM, NA#5 primary worker second shift indicated that once the resident was placed in bed she remained in place. She added that the resident's bed was elevated slightly and on occasion staff would have to reposition the resident to keep her head elevated per the sign posted above bed. She added that the lap buddy was on at all times and she did not know when it should be removed other than bathing/care etc. She indicated that she had not seen the resident lean in any direction.

During a meal observation on 1/10/13 at 8:00AM to 8:28AM, Resident#39 was seated in wheelchair without lapbuddy, wheelchair was facing the wall and not under the table. Resident#39 was being fed from a side angle position. Resident#39 was seated in an up right position without leaning in either direction while staff fed breakfast. She had a wash cloth in left hand and no splint on right. NA #2 fed Resident #39 and there was no leaning in any direction, no involuntary or repitltive movements and no behaviors. Resident #39 was very calm and cooperative. The right arm was hanging over arm rest in relaxed postion without splint and or hand roll/palm guard in left hand.

During an interview on 1/10/13 at 10:46AM, three family members indicated that the family had reported episodes of Resident#39 wheezing and

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F 241	Continued From page 13 the nursing staff stated they would put the sign above the bed to remind staff to elevate the resident to reduce wheezing and they did not request the information be posted. There was no family request for the signage posted, came in one day and the information was posted. Review of the medical record for Resident #39 did not provide documentation of discussion or permission for the provision of care to be posted above the bed. Additional, review of the admission packet did not include consent for provision of care to be posted in resident rooms.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	For Resident #39, a corrected care plan has been completed including the frequency and duration for the application and removal of restraints and splints (Attachment 8). All other Resident care plans will be reviewed and any corrections made no later than February 8, 2013. Systemically, a random audit will be performed by Corporate RAC and findings reported to Administrator for appropriate action. Any findings will be brought to quarterly Quality Assurance meeting (Attachment 7).	2/8/13

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F 279	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop a comprehensive care plan with identify quantifiable, measurable objectives with time frames for 1 of 3 residents with restraints and splints. The findings included; Resident #39 admitted to the facility on 2/17/09 and readmitted 10/5/12. The diagnoses included congested heart failure, alzheimer dementia, hypertension, pacemaker , and osteoarthritis. The Minimum Data Set(MDS) dated 11/1/12, indicated short and long term memory and decision making impairment. She required extensive to toal assistance with acitivies of daily living. Resident #39 was also coded as chair to prevent rising and with upper body contracutres. Review of the presented contracture assessment dated 2/17/10, identified limited range of motion of bilateral shoulders, elbows, very limited left wrist/fingers, moderate right wrist/fingers. There was no physician order documented for the use of splints presented. Review of the care plan dated 11/7/12, identified the problem as; Resident #39 had the potential for discomfort, injury and loss of autonomy related to the use of bolster pads and lap buddy when in wheelchair. The goal included that Resident #39 would be free from discomfort and injury and autonomy would be maintained at highest possible level. The approaches included Resident #39 would be reminded to use the call light for assistance, exercise to maintain range of	F 279		

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F 279	Continued From page 15 motion, attend activities and provide adequate stimulation and assess for least restrictive restraint. There was no frequency of when to apply or remove the restraint documented. Review of the care plan dated 11/7/12, did not address Resident #39 use of splints. Section titled, enabler/phsycial restraint identified the intervention as exercise to maintain range of motion. There was no indication of frequency for range of motion or application of splints. During an interview on 1/9/13 at 2:47PM, DON indicated that the care plan should include the frequency and duration for the application and removal of restraints and splints. During an interview on 1/9/13 at 4:00PM, Minimum Data Set(MDS) coordinator indicated that the frequency and use of the splints and restraints would be included on the care plan to include when to apply/remove and the restorative program would also be on restorative care plan.	F 279		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family	F 318	For Resident #39, a new care plan was completed (Attachment 8). Orders were obtained from physician for range of motion and splinting application (Attachment 9). For all other Residents, care plans, assessments, and physician orders were reviewed to ensure all Residents needing range of motion and splinting had the appropriate documentation. All Residents will be reviewed and assessed every 30 days.	2/8/13

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F 318	Continued From page 16 Interviews and record review, the facility failed to obtain physician order for the use of splints and assessed/evaluated for 1 of 3 sampled residents with contractures. The findings included; Review of the policy titled " Contractures " dated 7/30,2011, read in part; residents of the facility would be given care to prevent formation and progression of contractures and deformities Procedure included a contracture assessment would be done and the physician notified. If indicated, orders would be received from the physician specific to the contractures and the resident. The charge nurse would update document weekly for residents who have contractures. Nurse manager or designated registered nurse would monitor compliance and notify the attending physician if progression of the contracture occurs. Restorative program dated 7/30/2011, read in part; range of motion was given at bath time and at bedtime to all residents needing assistance in activities of daily living, hand rolls would be used when hands were contracted or beginning to show signs of contractures. Resident #39 admitted to the facility on 2/17/09 and readmitted 10/5/12. The diagnoses included congested heart failure, alzheimer dementia, hypertension, pacemaker , and osteoarthritis. The Minimum Data Set(MDS) dated 11/1/12, indicated short and long term memory and decision making impairment. She required extensive to toal assistance with acitivies of daily living. Resident #39 was also coded as chair to prevent rising and with upper body contracutres. Review of the presented contracture assessment dated 2/17/10, identified limited range of motion	F 318	Findings from any inappropriate documentation will be reviewed at the quarterly Quality Assurance meeting (Attachment 7.)	2/8/13

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F 318	Continued From page 17 of bilateral shoulders, elbows, very limited left wrist/fingers, moderate right wrist/fingers. There was no physician order documented for the use of splints presented. Reviewed of the occupational evaluation dated 7/28/10, revealed splints ordered tolerated 2-8 hours and restorative nurse trained in splint application, right hand goal met and with hand splint pain in left hand/fingers. Review of the care plan dated 11/7/12, did not address Resident #39 use of splints. Section enabler/phsycial restraint identified the intervention as exercise to maintain range of motion. There was no indication of frequency for range of motion or application of splints. Review of the care area assessment(CAA) dated 11/1/12 under falls documents: Resident #39 needed much assistance with activities of daily living due to progressive dementia. Resident was incontinent... Resident#39 has contractures to hands and splints applied. She needs much assistance with meals and has oral intake and weight monitored. Resident was not often alert and never oriented. She has routine skin assessment and ointments. Dining observation on 1/8/13 at 11:42AM, Resident #39 was seated at the dining room table with lap buddy in place and no palm guard or splints. The splint was in a recliner in the room During an obsevation on 1/9/13 at 8:07AM to 8:48AM, Resident #39 was being fed with lap buddy in place. Resident #39 did not have splint on right hand or palm guard in left hand.	F 318		

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F 318	Continued From page 18 During an observation on 1/19/13 at 10:10AM-11:00AM, blue hand splint still lying in recliner of chair. During an interview on 1/9/13 at 10:42AM, NA #1 indicated that residents that were in the restorative program there was no scheduled time to perform range of motion exercise or apply splints. Splints were applied when range of motion was performed as long as they were applied before 4:00PM. Second shift was responsible for the removal of splints. NA#1 indicated that she was unaware of how long Resident #39 should wear the splint or when she was last evaluated. Resident#39 had splint for a long time. During an observation 1/9/13 at 11:14AM, NA#1 provided range of motion and splint application of right arm to Resident #39 and washcloth in left hand. During an observation on 1/9/13 at 2:00PM, Resident#39 lying in bed with no physical movement and bed bolster pads in place. The wash cloth was in left hand and splint on right arm. The bed was elevated per sign above bed. During a meal observation on 1/10/13 at 8:00AM to 8:28AM, Resident#39 was seated in wheelchair without lapbuddy. Resident#39 was seated in an up right position without leaning in either direction while staff fed breakfast. She had a wash cloth in left hand and no splint on right. NA #2 fed Resident #39 and there was no leaning in any direction, no involuntary or reptitive movements and no behaviors. Resident #39 right	F 318		

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F 318	Continued From page 19 arm was hanging over arm rest in relaxed postion without splint and or hand roll/palm guard in left hand. During an interview on 1/9/13 at 2:40PM, the occupational therapist(OT) indicated that if the referral form was not in the restorative book then the resident was not being seen by the department. She added that a physician order was necessary for the use of splints. Resident was last seen for splint application 7/2/10. The order would include the frequency and duration for splint application and removal. OT reviewed the restorative book and could not find a referral or an order for the use or continuation of the splints. During an interview on 1/9/13 at 2:47PM, the DON indicated that there was no physician's order for splints and splints should not be applied without orders. DON acknowledged that there was no system in place for assessment and transition process for restorative to include the frequency and use of splints. Physician ' s orders should be clear as to what was expected for the use of splint application. During an interview on 1/913 at 4:48PM, NA#4 indicated that Resident#39 supposes to wear splints when up and removed when in the bed. During an interview on 1/9/13 at 4:59PM, NA#5 primary worker second shift indicated that she did not know when the splints were applied to the resident or when they were removed. She added if they were on she would remove them when	F 318		

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F 318	Continued From page 20 providing care there are times they are not on so she performs her nightly routine. During an interview on 1/10/13 at 10:46AM, three family members indicated that they had not seen Resident #39 in any splints and did not know when or how often she was to wear the splints. Family stated that Resident #39 had not woren splints in months, they never knew when they should be on cause they were either in a drawer or chair.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	The physician in consultation with the responsible party immediately discontinued the use of Haldol for Resident #12 during Survey. For all other Residents, the MDS Coordinator will accurately assess for unnecessary drug use in Section N of the Comprehensive Assessment. The Director of Nursing will consult with the pharmacist and physicians monthly to consider gradual dose reductions. The pharmacy consultant will report at the quarterly Quality Assurance meeting at the success of gradual dose reduction follow-up (Attachment 7).	2/8/13

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F 329	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and physician interview the facility failed to provide indications and identify target behaviors for the use of an antipsychotic medication Haldol for one of ten sampled residents for unnecessary medications. Resident #12 The findings were: Resident #12 was admitted on 8/16/2011 with diagnosis of Alzheimer ' s disease. Review of the pharmacy consult report dated 8/30/11, addressed to the physician, noted a recommendation for a diagnosis for the use of Haldol. Review of the physician ' s response, dated 9/21/11, gave a diagnosis of Dementia with associated behavioral disturbances. Review of the pharmacy consult for the month of September 2012 revealed recommendations to nursing for target behaviors to be used on the behavior monitoring flow sheets. Review of the Minimum Data Set (MDS) dated 10/18/122, a quarterly, assessed Resident #12 with no use of antipsychotic medication but did indicate the use of an antidepressant. The quarterly MDS assessed no indications of psychosis, with no physical or verbal behaviors and no behaviors of rejection of care. A care plan dated 10/22/12, identified a problem for risk of injury related to possible side effects or adverse reactions of prescribed psychotropic	F 329		

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medications. The goal included Resident #12 would not experience any side effects or adverse reactions of prescribed psychotropic medications. The approaches for staff to take included observation for antipsychotic side effects of somnolence, insomnia, dizziness, constipation, dry mouth, tardive dyskinesia, dyspepsia, hyperglycemia and weight gain; administer antipsychotic medication as prescribed; consult with pharmacy and physician or authorized assistant to consider gradual dose reduction.

The care plan dated 10/22/12, also identified a problem of a history of anxiety related to a diagnosis of depression as evidenced by episodes of " whining/crying. " The goal included Resident #12 would allow staff to redirect her to a quiet area during each episode of agitation/anxiousness. The approaches for staff to take included monitoring of behaviors related to mood state; agitation with crying and yelling, initiate behavior monitoring, and observe for patterns. Staff was to provide tactile support, hand holding, etc. If Resident #12 was expressing anger with self or others, staff was to attempt to determine the source of anxiety and encourage appropriate outlets for expression.

Review of the " Documentation of Behavior " flow sheets for the months of January 2012 to March 2012 and May 2012 to December 2012 revealed no target behaviors were identified for use of the Haldol. The month of April had "crying" identified as a target behavior.

A second request was made to nursing by the pharmacy consultant on 12/19/12 to use target

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F 329	Continued From page 23 behaviors on the behavior monitoring flow sheets. Observations of Resident #12 on 1/10/13 at 8:00 AM revealed she was sitting in dining room and no behaviors of yelling observed. Observations on 1/10/13 at 9:44 AM of Resident #12 revealed she was in bed and no behaviors of yelling observed. An interview with the physician on 1/10/13 at 9:59 AM revealed he had assumed responsibility for Resident #12 ' s care on that date. Continued interview revealed he would review the medical record for the indication(s) of the use of the Haldol. Observations on 1/10/13 at 10:11 AM revealed the restorative aide was working with Resident #12. The restorative aide applied heat to the back of the knees for Resident 12. Observations of the resident during the heat application revealed no behaviors were exhibited. The restorative aide reported Resident #12 had been " crying " and complained of pain when range of motion was attempted to her hands. The restorative aide had stopped the range of motion and applied heat to her knees. The resident had allowed the restorative aide to stretch the legs after heat application. The restorative aide was able to stretch Resident #12 ' s legs within a few inches to the bed surface. Prior to the heat application and stretching, the legs were bent at the knees and next to her chest. There were no behaviors exhibited during provision of her care. Follow up interview with the physician on 1/10/13 at 10:15 AM revealed he spoke with the resident's	F 329		

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F 329	Continued From page 24 responsible party by phone. The responsible party informed him the Haldol had been started about 4 years ago due to behaviors of combativeness during care. Since the resident was no longer exhibiting those behaviors, he would stop the Haldol and also review other medications. Interview on 1/10/13 at 3:15 PM with Administrative staff #1 revealed she had no documentation the pharmacy recommendations for target behaviors had been addressed.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the	F 334	On August 1, 2013, all responsible parties will be mailed all current educational information including benefits, risks, and side effects of receiving the flu and/or pneumococcal vaccine. Included will be a consent form for them to sign accepting or declining the flu and/or pneumococcal vaccine after reviewing the educational material. Beginning on August 1, 2013, this information will be presented at the time of admission for new Residents (Attachment 10). The percentage of participation will be discussed at the October quarterly Quality Assurance meeting (Attachment 7).	2/8/13

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F 334	Continued From page 25 influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

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F 334	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on medical record reviews, family interview, staff interview and policy review the facility failed to provide documented education prior to administration of the vaccines to one of six sampled residents for immunization review. Resident # 16 Findings include: Review of the policy from the Infection Prevention Manual for Long Term Care with a revision date of " 2009 " revealed consent forms for Influenza Vaccine Administration Consent Form. " This form contained the following information: " Statement of informed consent: By signing below, you agree to the following: ' I have read or have had explained to me the information in this pamphlet about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me or to the person named below for who I am authorized to make this request. " Resident #16 was admitted to the facility on 11/25/2010 with diagnosis of Hypertension, Anxiety, Depression and Urinary Tract Infection. Review of the Minimum Data Set (MDS) revealed Resident #16 had long and short term memory impairment. This MDS documented Resident #16 had received the Influenza vaccine on 10/17/2012.	F 334		

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F 334	Continued From page 27 Review of the medical records for Residents #16 revealed the consent form did not have documentation that education was provided to the responsible party. The Immunization Form in Resident #16 ' s medical record documented the immunization, date of administration and lot number of the medication. The provision of education regarding the influenza vaccine was not documented on the Immunization Form. Medical record review revealed authorization, and administration, but no education regarding influenza and/or pneumococcal immunizations. Interview on 1/10/13 at 10:35 AM with a family member of Resident # 16 revealed she had not been given educational information before the influenza vaccine was administered on 10/14/12. Interview on 1/10/12 at 3:00 PM with Administrative nurse #1 revealed education was provided on admission. Consent to administer the influenza vaccine was obtained each year. No explanation could be provided as to the absence of documented education prior to administration of the vaccine. Documentation of education could not be provided for the Resident #16.	F 334	Items mentioned were removed as soon as they were found.	2/8/13
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	In-service presented to Nursing Staff on proper labeling, storage, and discarding outdated medications (Attachment 11). Medication Room and Refrigerator will be checked nightly by a Staff Nurse with a check sheet (Attachment 12).	

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F 431	Continued From page 28 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and policy review the facility failed to discard expired multi-dose vial medications and expired intravenous fluids in one of two medication rooms (East hall) and maintain one of two medication refrigerators at a temperature of 36 degrees to 46 degrees Fahrenheit. (East hall) The findings were:	F 431	Any discontinued meds, expired meds, or discontinued IV fluids will be returned to the pharmacy. A Supervisor will check the areas weekly with a check sheet (Attachment 13). All check sheets will be turned in to the Director of Nursing. Compliance will be addressed at the quarterly Quality Assurance meeting (Attachment 7). The medication refrigerators will be checked nightly for proper temperatures with a log sheet (Attachment 14). The Supervisor will also make weekly checks for compliance using temperature log sheet (Attachment 15). If refrigerator temperatures are not within correct parameters, a maintenance work order will be completed (Attachment 16). Accuracy of medication refrigerator temperatures will be discussed at the quarterly Quality Assurance meeting (Attachment 7).	2/8/13

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F 431	Continued From page 29 Review of the policy " Medication Discard Dates " with a revision date of 7/2012 revealed the following instructions for " Special Storage/Directions " and " Discard Date(s) " : " Insulin Vials: " Refrigerate, Date/Initial vials when opened, and discard 28 days after opening. " " Miscellaneous Tubersol/Aplisol, Tuberculin PPD vial: discard 30 days after opening. " 1. During observations of medication storage on the East hall medication room on 1/9/13 at 7:58 AM, the following were found to be expired: A. Located in a medication back up box in the refrigerator was a multi-dose vial of novolin 70/30 insulin that was opened and not dated. B. A basket with opened multi-dose immunizations: - Tubersol opened with no date and - Tuberculin purified protein derivative, diluted Aplisol dated 10/12/12. C. Located in a cabinet were 3 bags of 250cc intravenous fluids (IV) of .9% normal saline solution, with an expiration date of December 2012 and one bag with an expiration date of September 2012. Review of a policy " Storage of Refrigerated Medications " that was not dated revealed " B. The temperature of all refrigerators containing medications shall be maintained at (sic) between 36 degree F. to 46 degree F. " 2. During observations of the East hall	F 431		

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F 431	Continued From page 30 medication room on 1/9/13 at 7:58 AM, the temperature log of the refrigerator for medications was reviewed. The log documented temperatures for each day of the month. Review of the log revealed the following dates the temperatures were below the designated 36 degrees F: - 12/31/12 a temperature of 32 degrees F - 12/30/12 a temperature of 32 degrees F - 1/1/13 a temperature of 32 degrees F - 1/5/13 a temperature of 32 degrees F - 1/7/13 a temperature of 34 degrees F. Interview on 1/9/13 at 10:00 AM with Administrative staff #1 revealed the multi-dose vials had expired and should have been discarded. The IV fluids had expired and should have been removed. Interview with Administrative staff #1 was conducted on 1/10/13 at 1:23 PM. During this interview, it was explained the temperature range for the storage of medications in the refrigerator should be between 36 to 42 degrees F. Maintenance was not aware of the temperatures being out of range. It was her expectation the floor nurses who checked the temperatures would have informed the maintenance staff.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	No specific Resident was identified to have been affected by the deficient practice. Once the Director of Nursing was notified of the deficient practice, NA #2 was reprimanded and the wire basket was removed from the room and the hallway.	2/4/13

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F 441	Continued From page 31 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and facility policy review, the facility failed to transport linens to prevent cross contamination by one of five direct care staff on the 7-3 shift. (Aide #2)	F 441	In-services were completed and will continue for present Staff as well as new Staff on Infection Control Including the process of using clean linen (Attachment 17).. The Charge Nurse on the unit will monitor the NA's use of linen, wearing gloves outside in the hallway, and maintaining proper infection control. "Just in time" training on the units for infection control will continue on-going by the Supervisors. All data gathered by in-services will be taken to the quarterly Quality Assurance meeting (Attachment 7).	2/18/13

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F 441	Continued From page 32 The findings were: Review of the policy " Facility Laundry Procedure Nursing Personnel Procedure " dated 7/30/11 revealed the following instructions for nursing staff: "...2. All clean linen will remain on the clean linen cart and zipped until removed for usage... 5. Clean linen shall remain covered and staff to follow infection Control measures when delivering and removing linen from resident ' s room. 6. Soiled linen shall be bagged and transported either directly to the laundry shute (chute) located on each floor or deposited into the soiled linen containers located in the soiled linen rooms on each floor. " Observation on 1/10/13 at 8:55 AM revealed a metal cart was located in room #683. There were two residents residing in the room. The metal cart contained linen that was stacked for multiple residents ' use and was left uncovered. Continued observations revealed aide #2 removed linen from the metal cart in room #683 and transported the linen to room # 681. Aide #2 carried the linen against her clothing. Aide #2 was observed using the linen on the bed for a resident in room #681 A. Observations on 1/10/13 at 9:40 AM revealed aide #2 was in room #677 changing the linen on bed A. The linen that had been on bed A was removed. Aide #2 was observed leaving room # 677 A with her gloves on, proceeded into the hall and into room #683. Aide #2 removed a cloth pad from the stacked linens touching other linens in the metal cart. Aide #2 returned to room #677	F 441		

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F 441	Continued From page 33 and placed the cloth pad on the resident's bed in room # 677 A. Observations on 1/10/13 at 10:07 AM revealed aide #2 removed personal clothes from the closet for the resident in room # 683 A. Aide #2 placed the clothing on top of the linen in the metal cart. Observations on 1/10/13 at 10:45 AM revealed linen lying on the floor beside the resident ' s bed in room # 683. Interview with aide #2 during the observations revealed the linen was dirty. Aide #2 replied " the linen is not supposed to be put on the floor. " Observations on 1/10/13 at 11:07 AM revealed the metal cart with the stacked linen was moved from room #683 to room #687. This was the only metal cart observed on the hallway on 1/10/13. Interview with aide #2 on 1/10/13 at 11:10AM revealed she had put clean linen on the metal cart to take down the hall and used it for different residents on her assignment. Continued interview revealed she had left it in a resident's room. Aide #2 was asked "How were you trained to handle clean linen?" She replied "Get the linen from the cart, take it down the hall. Once it is in a resident's room, it should not be brought back out." She further stated she did this practice to save time going up and down the hall. Interview with Administrative staff member #1 on 1/10/13 at 2:00 PM revealed the staff was expected to go to the linen closet to get clean linen. A clean linen closet was located at the top of the hall. The staff could keep the dirty linen cart at the room where they were working. If staff	F 441		

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F 441	Continued From page 34 needed to transport dirty linen down the hall, they could use either a pillow case or a plastic bag. Her expectation of staff would be to put the dirty linen in the dirty linen cart. Further interview revealed the staff was not to take clean linen room to room.	F 441		

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I (211) construction, 3 story building without a complete automatic sprinkler system. The facility at the time of the inspection did not have 100% sprinkler coverage. · On August 13, 2008, the Center for Medicare & Medicaid Services (CMS) published a final rule entitled " Medicare and Medicaid Programs; Fire Safety Requirements for Long Term Care Facilities, Automatic Sprinkler System. " · This regulation requires all long term Facilities to be equipped with a supervised automatic sprinkler system by August 13, 2013, installed in accordance with the 1999 edition of the National Fire Protection Association ' s (NFPA) " Standard for the Installation of Sprinkler System " (NFPA13). · Facilities with existing sprinkler systems should review their sprinkler system to determine if they meet the requirements of the 1999 edition of NFPA 13. · Web Link - https://www.cms.gov/surveycertificationgeninfo/downloads/scletter09-04.pdf The deficiencies determined during the survey are as follows:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/8/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 2/22/13 at approximately 9:00 AM onward the following was noted: 1) The soiled laundry chute discharge room is not covered with sprinkler protection. 2) The storage room corridor door B420, ~~was~~ not self closing, and the latching hardware was not in good condition. 42 CFR 482.41(a)	K 029	1. The soiled laundry chute discharge room will be sprinkled. 2. Spring loaded hinges and a new door latch will be installed. All other non sprinkled rooms were checked to meet the sprinkling requirements and an ongoing checklist will be done. All doors are on a checklist for monitoring by environmental services for correct closures and working latches. Any concerns will be brought to the Quarterly Quality Assurance meeting.	4/8/13
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 2/22/13 at approximately 9:00 AM onward the following was	K 038	Due to new construction, as of March 19th stairwell #5 will no longer be a required exit.	N/A

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K 038	Continued From page 2 noted: 1) Exit stairwell #5 did not have a solid surface walkway leading to the public way. 42 CFR 482.41(a)	K 038		
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on Friday 2/22/13 at approximately 9:00 AM onward the following was noted: 1) The exit discharge illumination was observed as noncompliant: There was no exit discharge lighting at stairwell #5 exit. 2) The side walk leading from level 5 front exit dining room was not illuminated to the public way. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 045	1. Due to new construction, as of March 19th stairwell #5 will no longer be a required exit. 2. For level 5 front exit a 2 bulb lighting fixture will be installed meeting the 1 foot candle criteria this fixture will be connected to the life safety system. All other exit areas were checked for proper illumination. There will be weekly checks to make sure exit lighting is working properly. Any concerns with proper exit lighting will be brought to the Quarterly Quality Assurance meeting.	4/8/13
K 144	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

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K 144 SS=F	Continued From page 3 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Friday 2/22/13 at approximately 9:00 AM onward the following was noted: 1) The emergency generator when tested under load took in excess of 11 seconds to transfer from normal power to emergency power. 2) Upon testing the emergency generator under load the generator annunicator panel did not indicated generator supplying emergency power when connected. 42 CFR 482.41(a)	K 144	1. On day of survey contracted generator company came and corrected time frame issue. Weekly generator checks will be conducted. (see attachment 1) 2. On same day of survey contracted generator company also corrected annunciator panel. Weekly checks are also done on panel. (see attachment 1) Any generator concerns will be reported at the Quarterly Quality Assurance meeting.	4/8/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on Friday 2/22/13 at approximately 9:00 AM onward the following was noted: 1) The oven in the activity room was not equipped	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 147	Continued From page 4 with a disconnect switch that would prevent the stove from being turned on accidentally when not in use. 42 CFR 482.41(a)	K 147	A disconnect switch has been installed to the oven in the activity room. All other appliances accessible to residents have been checked to insure that they have an emergency shut off or have been taken out of service. Environmental services will monitor all appliances accessible to residents for proper safety disconnects. Any concerns will be brought to the Quarterly Quality Assurance meeting.	4/8/13

FF